

NHICS 255 | MASTER RESIDENT EVACUATION TRACKING



1. INCIDENT NAME					2. OPERATIONAL PERIOD				
					DATE:		FROM:		TO:
TIME:		FROM:		TO:					
3. RESIDENT EVACUATION INFORMATION									
RESIDENT NAME			MEDICAL RECORD #			MED RECORD SENT		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DISPOSITION		MODE OF TRANSPORT	ACCEPTING FACILITY NAME & CONTACT INFO		TIME FACILITY CONTACTED & REPORT GIVEN	TRANSFER INITIATED (TIME/ TRANSPORT CO.)		MEDICATION SENT	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> HOME <input type="checkbox"/> FACILITY TRANSFER <input type="checkbox"/> TEMP. SHELTER								MD/FAMILY NOTIFIED	<input type="checkbox"/> YES <input type="checkbox"/> NO
								ARRIVAL CONFIRMED	<input type="checkbox"/> YES <input type="checkbox"/> NO
RESIDENT NAME			MEDICAL RECORD #			MED RECORD SENT		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DISPOSITION		MODE OF TRANSPORT	ACCEPTING FACILITY NAME & CONTACT INFO		TIME FACILITY CONTACTED & REPORT GIVEN	TRANSFER INITIATED (TIME/ TRANSPORT CO.)		MEDICATION SENT	<input type="checkbox"/> YES <input type="checkbox"/> NO
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								ARRIVAL CONFIRMED	<input type="checkbox"/> YES <input type="checkbox"/> NO

PURPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
ORIGINATION: RESIDENT SERVICES BRANCH DIRECTOR
COPIES TO: OPERATIONS AND PLANNING SECTION CHIEF

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3. RESIDENT EVACUATION INFORMATION (continued)							
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					MD/FAMILY NOTIFIED		<input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> HOME <input type="checkbox"/> FACILITY TRANSFER <input type="checkbox"/> TEMP. SHELTER							ARRIVAL CONFIRMED	<input type="checkbox"/> YES <input type="checkbox"/> NO	
RESIDENT NAME				MEDICAL RECORD #				MED RECORD SENT	<input type="checkbox"/> YES <input type="checkbox"/> NO
DISPOSITION	MODE OF TRANSPORT	ACCEPTING FACILITY NAME & CONTACT INFO	TIME FACILITY CONTACTED & REPORT GIVEN	TRANSFER INITIATED (TIME/ TRANSPORT CO.)	MEDICATION SENT		<input type="checkbox"/> YES <input type="checkbox"/> NO		
					MD/FAMILY NOTIFIED		<input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> HOME <input type="checkbox"/> FACILITY TRANSFER <input type="checkbox"/> TEMP. SHELTER							ARRIVAL CONFIRMED	<input type="checkbox"/> YES <input type="checkbox"/> NO	
RESIDENT NAME				MEDICAL RECORD #				MED RECORD SENT	<input type="checkbox"/> YES <input type="checkbox"/> NO
DISPOSITION	MODE OF TRANSPORT	ACCEPTING FACILITY NAME & CONTACT INFO	TIME FACILITY CONTACTED & REPORT GIVEN	TRANSFER INITIATED (TIME/ TRANSPORT CO.)	MEDICATION SENT		<input type="checkbox"/> YES <input type="checkbox"/> NO		
					MD/FAMILY NOTIFIED		<input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> HOME <input type="checkbox"/> FACILITY TRANSFER <input type="checkbox"/> TEMP. SHELTER							ARRIVAL CONFIRMED	<input type="checkbox"/> YES <input type="checkbox"/> NO	

4. PREPARED BY	PRINT NAME: _____ DATE/TIME: _____	SIGNATURE: _____ FACILITY: _____
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NHICS 255 | MASTER RESIDENT EVACUATION TRACKING



INSTRUCTIONS

- PURPOSE:** Records the disposition of residents during a facility evacuation.
- ORIGINATION:** Resident Services Branch Director
- COPIES TO:** Operations Section Chief and Planning Section Chief
- NOTES:** Completed with information taken from each NHICS 260 - Resident Evacuation Tracking form. If additional pages are needed, use a blank NHICS 255 and repaginate as needed

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Resident Evacuation Information	
	Resident Name	Enter the full name of the resident.
	Medical Record #	Enter medical record number.
	Medical Record Sent	Indicate yes or no.
	Disposition	Indicate the resident's disposition.
	Mode of Transport	Indicate the mode of transport (CCT, ALS, BLS, Van, Bus, Car)
	Accepting Facility Name and Contact Info	Enter accepting (receiving) facility name and contact information
	Time Facility contacted & report given	Enter time prepared (24-hour clock).
	Transfer Initiated (Time/Transport Co.)	Enter time, vehicle company, and identification number.
	Medication Sent	Indicate yes or no.
	MD/Family Notified	Indicate yes or no.
Arrival Confirmed	Indicate yes or no.	
4	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.